



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NORTHWEST TEXAS HOSPITAL 1201 LAKE WOODLANDS DR #4024 WOODLANDS TX 77380	MFDR Tracking #: M4-11-0114-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: AMARILLO ISD Box #: 11	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as taken from the Request for Reconsideration dated July 27, 2010: "Our company represents Northwest Texas Hospital in the collection of its outstanding accounts. In this regard, we are providing you with the copy of the UB, EOB, and Medicare reimbursement for CPT codes 97022, 97110, and 97124 in order to reprocess the claim for patient [injured employee] for the services rendered on 04/01/10 – 04/29/10 in the amount of \$3851.50 Claim total allowed is \$1453.00, paid \$865.28, and underpaid \$ 587.72."

Amount in Dispute: \$587.72

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter is in response to the Medical Dispute Resolution referenced above. After a review of the claim, it does not appear that additional benefits are due. We have reviewed the supporting documentation submitted by the hospital and it does not reflect the current applicable fee schedule. The information refers to the hysician fee schedule payable at 200% rather than the new Medicare facility reimbursement amount payable at 200%. Attached please find copies of the Alternate D62's, the Preauthorization for services, the UB-04, itemized bill, and the 2 Requet for Reconsiderations that were submitted for processing."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
04/01/10, 04/07/10, 04/08/10, 04/13/10, 04/15/10, 04/22/10, 04/27/10, 04/29/10	CPT Code 97110	$(54.32 \div 36.0791) \times \$27.81 = \$41.87 \times 15 = \$628.05 - \$628.05$ (carrier payment)	\$261.87	\$0.00
04/07/10, 04/08/10, 04/13/10, 04/15/10, 04/22/10, 04/27/10, 04/29/10	CPT Code 97124	$(54.32 \div 36.0791) \times \$22.51 = \$33.89 \times 7 = \$237.23 - 237.23$ (carrier payment)	\$77.91	\$0.00

04/01/10, 04/07/10, 04/08/10, 04/13/10, 04/22/10, 04/27/10, 04/29/10	CPT Code 97022	N/A	\$0.00	\$0.00
			Total Due:	\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

This request for medical fee dispute resolution was received by the Division on September 7, 2010..

- For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - 0222 – Charge exceeds Fee Schedule allowance.
 - 0361 – Services delivered under an OTPT Occupational therapy plan of care.
 - 0015 – 15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.
 - 0019 – 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 000J – Final adjudication.
- This dispute pertains to physical therapy/occupational therapy provided to the injured employee performed in a facility setting.
- Division rule at 28 TAC §134.403(h) states, in pertinent part, that “for medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined I subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.”
- The requestor is seeking additional reimbursement for CPT Code 97110 (15 units), therapeutic exercises, however, in accordance with Division rule at 28 TAC §134.203(c)(1) the established workers compensation conversion factor divided by the Medicare conversion factor multiplied by the Medicare participating amount shall be calculated as shown in Part IV of this decision. The MAR amount is \$628.05; the respondent paid \$628.05. Additional reimbursement is not recommended.
- The requestor is seeking additional reimbursement for CPT Code 97124 (7 units), therapeutic procedures, however, in accordance with Division rule at 28 TAC §134.203(c)(1) the established workers compensation conversion factor divided by the Medicare conversion factor multiplied by the Medicare participating amount shall be calculated as shown in Part IV of this decision. The MAR amount is \$237.23; the respondent paid \$237.23, Additional reimbursement is not recommended.
- The requestor is seeking payment for CPT Code 97022, whirlpool therapy, in the amount of \$247.94. According to the preauthorization approval dated March 19, 2010, submitted by the respondent, approval was given for no more than 4 units per session of the following modalities: 97010, 97018, 97039, 97110, 97124, 97535, 97504, and 97799 (wound care). This code was not one of the codes preauthorized; therefore, reimbursement is not recommended.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
 28 Texas Administrative Code §133.305, §133.307, §134.203, §134.403
 Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.